Franklin County
Where Government Works

☐ Administration
80 E.Fulton Ave
Col. OH 43215-5174
(614) 462-4000
FAX (614) 462-6451

☐ North Center
345 E. 5th Ave.
Col,OH 43204-2819
(614) 719-8600
FAX (614)719-8607

☐ NorthEast Center
3443 Agler Rd.
Col. OH 43219-3385
(614)428-6703
FAX (614) 428-6708

☐ South Center
3723 S. High St.
Col.OH 43207-4011
(614) 492-6982
FAX (614)492-6909

☐ East Center
1055 Mt.Vernon Ave
Col.OH 43203-1519
(614) 251-6300
FAX (614) 251-6347

☐ West Center
314 N. Wilson Rd.
Col.OH 43207-6221
(614) 308-1200
FAX (614) 308-1225

Franklin County Department of Job and Family Services

www.FranklinCountyOhio.gov

Employer Name:_____

Address:_____

_____

This information will be used for:

☐ OWF (ADC)
☐ Medicaid
☐ Disability Assistance
☐ Food Stamps
☒ Child Care (TitleXX)
☐ Other: _____

I agree that the company/person listed above may complete this form and return it to Franklin County Department of Job and Family Services. I am aware of my responsibilities to report completely and fully all acts which bear upon my eligibility for all public assistance. I realize that if the requested information reveals that I have improperly reported my situation, the information may be given to the prosecuting attorney for possible civil action or criminal prosecution.

_____ _____
Signature of Applicant/Recipient Date

Prompt completion and return of this form will aid both our agency and the client in the completion of this case. If you are returning the verification by mail, please use the agency envelope provided and return it within ten working days. Thank you

1. Company Name_____ Federal ID Tax Number_____
   Company Address_____ _____
2. Starting date of employment_____ 3. Rate of pay_____
4. How often employee is paid_____ Day of week paid_____

*IF EMPLOYMENT HAS ENDED, SKIP TO #6

5. Number of hours contracted to work a week:_____

HOURS SCHEDULED TO WORK

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Beginning							
Ending							

6. Gross earnings for the last four pay periods:

Pay received date	No. Hours Worked	Gross + Tips	Deductions

7. If employment has ended, date employment ended_____
8. Date of last check and gross amount of that check_____
9. Please indicate why employment was ended if applicable_____
   _____

_____ _____
Employer's Signature and Title Employer's Phone Number

For Office Use Only			
Name of FCDJFS Representative CHILDCARE	Unique Identifier FranklinCountyChildcare@fcdjfs.franklincountyohio.gov	Phone 233-2000	Fax
Case Number	Date 6/14/2012	Recipient	SS#

FCDJFS-534 (Rev. 3-2007)